Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT REHABILITATION CENTERS
2420 EAST RANDOL MILL RD
ARLINGTON TX 76011-6335

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-06-5236-01

MFDR Date Received
April 10, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:

"DOS 7/13/05, 7/18/05, 7/27/05: Services can not be considered global or Incidental to any other on that date.
DOS 10/18/08, 11/16/05 and 11/29/05: No EOB provided by the carrier yet.
DOS 9/20/05: All fee guidelines have been followed for these services."

Amount in Dispute: $315.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2005	Rehabilitation Services	$315.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 10, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 19, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 42 – [no explanation of this denial reason was found with the submitted materials]

Findings

1. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for disputed services October 18, 2005, November 16, 2005, or November 29, 2005. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B). These services, therefore, may not be reviewed for payment.
2. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202, effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. It further requires that to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with minimal modifications as provided in the rule. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%.
3. Reimbursement for the disputed services is calculated as follows:
   - Per Medicare payment policy, procedure code 95851, service date July 13, 2005, may not be reported with procedure codes 99213 and 97140 billed on the same date of service. Payment for this procedure is included in the payment for other services performed on the same date. Separate reimbursement cannot be recommended.
   - Per Medicare payment policy, procedure code 95831, service date July 18, 2005, may not be reported with procedure codes 99213 billed on the same date of service. Payment for this procedure is included in the payment for other services performed on the same date. Separate reimbursement cannot be recommended.
   - Per Medicare payment policy, procedure code 95851, service date July 27, 2005, may not be reported with procedure codes 99213 and 97140 billed on the same date of service. Payment for this procedure is included in the payment for other services performed on the same date. Separate reimbursement cannot be recommended.
   - Procedure code 97032, service date September 20, 2005, the insurance carrier denied payment for the second billed unit of the procedure with the explanation that "SERVICE(S) NOT BILLED WITHIN THE GUIDELINES ESTABLISHED BY TWCC RULE 134.202/CMS PAYMENT POLICIES EFFECTIVE 8/01/03." Review of the submitted medical documentation finds no information to support the second service unit as billed. The insurance carrier's denial reason is supported. Therefore, only one unit of service may be reviewed for payment. The Medicare payment amount for procedure code 97032 is $16.42. This amount multiplied by 125% results in a MAR of $20.53. This amount less the amount previously paid by the insurance carrier of $20.53 leaves an amount due to the requestor of $0.00. No additional payment is recommended.
   - As stated above, the requestor did not submit explanations of benefits detailing the carrier determination of payment for procedure code 99213, billed on service dates October 18, 2005, November 16, 2005, and November 29, 2005. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. Without documentation to support the insurance carrier's payment, or lack thereof, the Division cannot make a determination regarding the medical fee amounts for these disputed services. The requestor bears the burden of providing documentation to support that additional reimbursement is due. The requestor has failed to provide sufficient documentation to support that additional reimbursement is due for these disputed services; therefore, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 31, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.